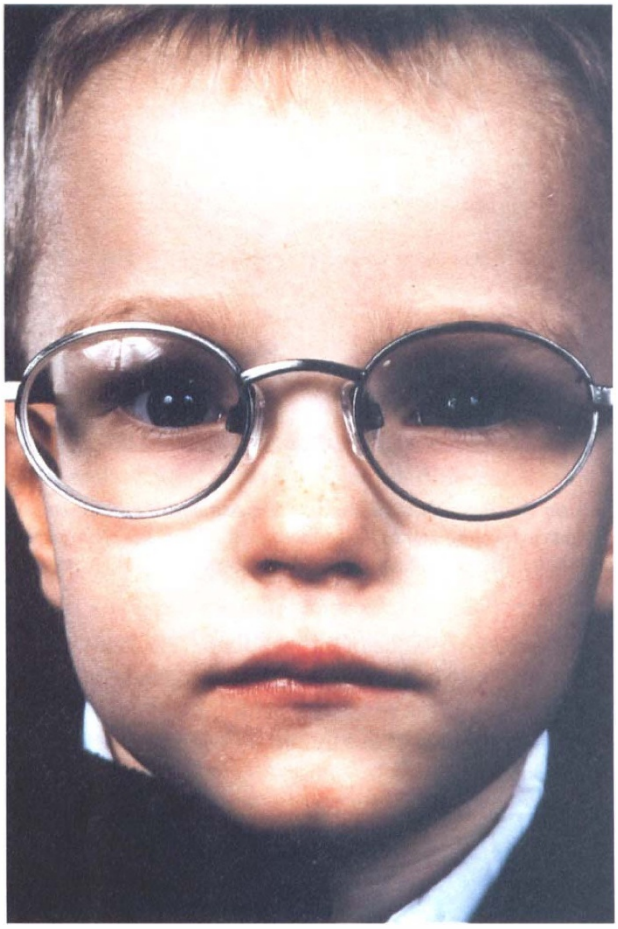

Fig. 2. *Spectacles with an appropriate prescription make the two eyes appear symmetrical in size.*

eye appeared unaffected. The microphthalmos may have been idiopathic but in view of the prematurity and the subsequent finding of a myopic fellow eye, retinopathy of prematurity was considered a possibility.

At the age of 2 years his right eye was highly myopic and had a visual acuity of 6/9 with a correction of −5.00 DS/+1.00 DC×90. The left eye had no perception of light. A prescription of +5.00 DS was given for this eye, which served as a counterbalance for the right lens and also had the effect of magnifying the microphthalmic eye to observers. The patient's eyes hence appeared symmetrical in size (Fig. 2).

Comment

The eyes are commonly judged to be the most prominent facial feature. This is particularly true for those wearing spectacles[1] and so can attract attention to any abnormalities of the eyes. It is thus desirable to strive for a good cosmetic appearance in such cases. The use of optical methods to improve cosmesis, particularly after orbital or facial reconstructive surgery, is well known to ocular prosthetists but little is written about it in the ophthalmic literature. Mittelviefhaus[2] has previously described cases in which the use of prismatic, hyperopic or myopic lenses improved the appearance of abnormal non-seeing eyes.

If the usual balance lens of −5.00 DS had been given to our patient, the cosmetic appearance would have been considerably worse. This case demonstrates how patients with deformities of the orbit or globe can benefit cosmetically if appropriate lenses are fitted in front of an ambylopic or blind eye.

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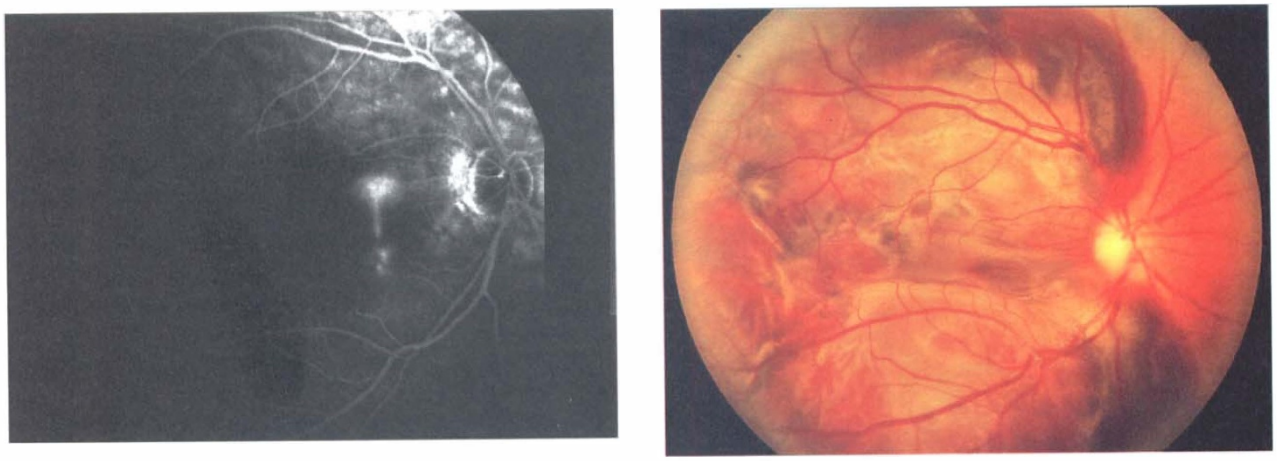
Sir,

Massive subretinal haemorrhage associated with central serous chorioretinopathy

Central serous chorioretinopathy (CSCR) is an exudative macular disease occurring in young healthy individuals commonly associated with serous pigment epithelial detachment. In most cases, CSCR is self-limiting and the majority of patients have excellent visual outcome. Some patients may develop persistent loss of vision due to irreversible damage to retinal pigment epithelium. Massive subretinal haemorrhage following CSCR is extremely rare.[1] We report a patient with a history of CSCR who developed massive submacular haemorrhage 5 years later.

Case report

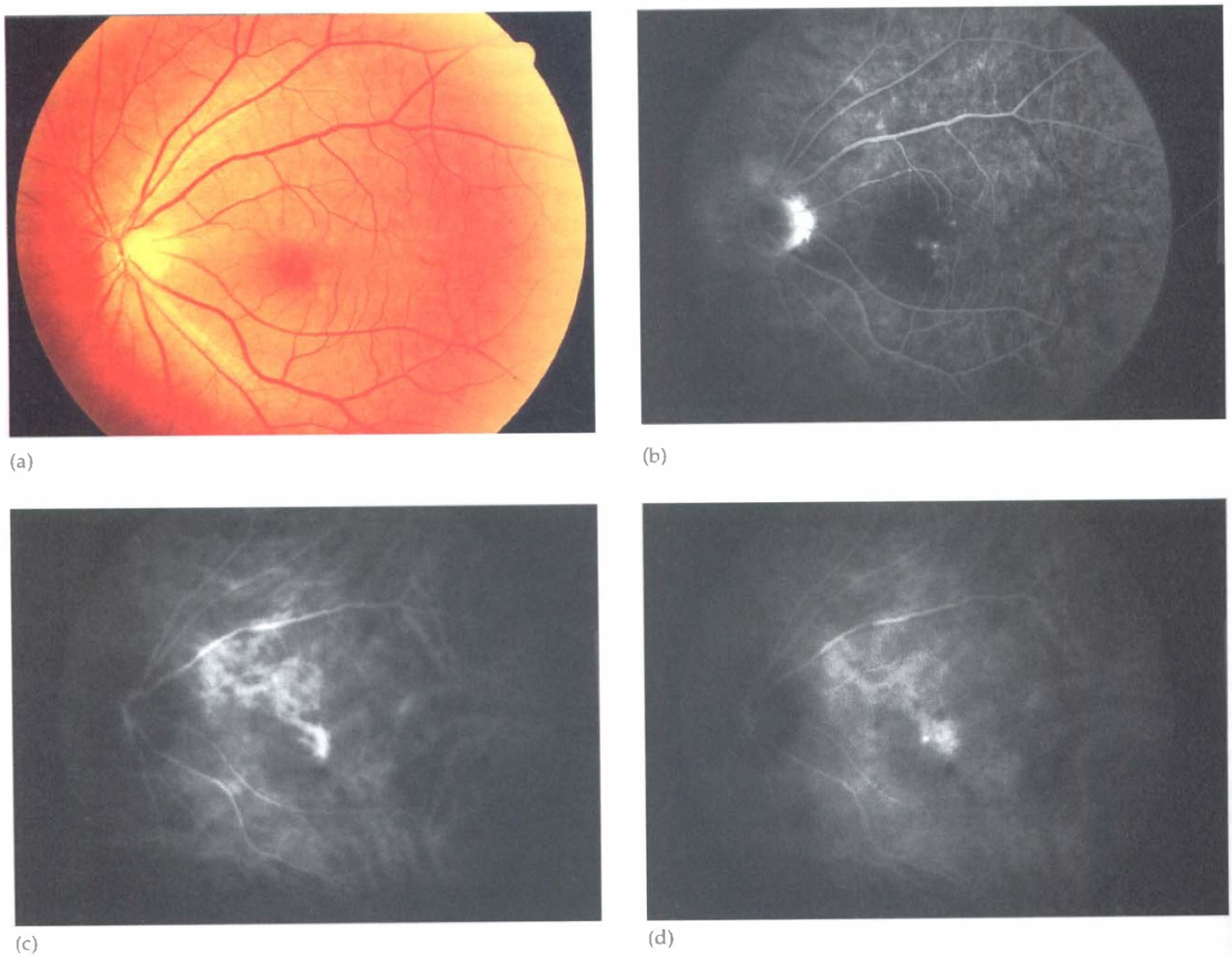
A 48-year-old healthy Chinese woman presented with a 2 week history of a sudden drop in right eye vision. She had a history of CSCR in the right eye 5 years previously and was treated with focal laser in another institution (Fig. 1a). The vision in both eyes remained normal until this episode. On examination, visual acuity was light perception and 20/30 over the right and left eye, respectively. Anterior segment and intraocular pressure were normal bilaterally. Fundus examination of the right eye revealed an extensive subretinal pigment epithelial (RPE) and choroidal haemorrhage with a few superimposed subretinal haemorrhages. The lesion involved almost the complete temporal half of the retina (Fig. 1b). Contact lens biomicroscopy of the left macula showed small serous RPE detachments with surrounding RPE changes temporal to the foveola (Fig. 2a). Fundus fluorescein angiography (FFA) revealed only blocked fluorescent in the right eye and small punctate hyperfluorescent RPE window defects with mild leakage in the left eye (Fig. 2b). Indocyanine green angiography



(a) (b)

Fig. 1. *Right eye. (a) Fluorescein angiogram (arteriovenous phase) 5 years previously showing a classical smokestack appearance of central serous chorioretinopathy nasal to the fovea. There is a retinal pigment epithelial (RPE) window defect inferior to the leakage point. (b) Fundus photograph on the day of presentation showing massive sub-RPE and choroidal haemorrhage with a few superimposed subretinal haemorrhages over the temporal half of the retina.*

(ICGA) of the right eye was not informative because of the blockage effect by the massive haemorrhage. In the left eye, ICGA showed a prominent hyperfluorescent dilated choroidal vessel in the early phase with a prominent punctate hot spot with a surrounding hyperfluorescent plaque in the late phase (Fig. 2c,d). Both B-scan ultrasonography and magnetic resonance imaging of the right eye were consistent with intraocular haemorrhage rather than tumour. Systemic survey was unremarkable.



(a) (b)

(c) (d)

Fig. 2. *Left eye. (a) Fundus photograph showing small serous RPE detachments with surrounding RPE changes inferotemporal to the foveola. (b) Fluorescein angiogram (late phase at 11 min 8 s) showing small punctate hyperfluorescent RPE window defects with mild leakage in the left eye. (c), (d) Indocyanine green angiograms (57 s and 5 min 43 s, respectively) showing a prominent hyperfluorescent choroidal vessel in the early phase with a prominent punctate hot spot with a surrounding hyperfluorescent plaque in the late phase.*

Submacular surgery was not advised because of the sub-RPE location of the haematoma and the late presentation. The patient, however, presented herself to another ophthalmologist and drainage of the sub-RPE blood clot was performed unsuccessfully, complicated by retinal detachment. Three months later the patient re-presented to our clinic with proliferative vitreoretinopathy and a detached retina and a final visual acuity of faint light perception.

Comment

Massive sub-RPE and choroidal haemorrhage is rarely due to CSCR or laser-induced iatrogenic choroidal neovascularisation (CNV). One of the differential diagnoses for the cause of sub-RPE haemorrhage is idiopathic polypoidal choroidal vasculopathy (IPCV). IPCV is typically described as a bilateral, peripapillary disease involving the inner choroidal circulation of middle-aged black women.[2] Subsequently, macular lesions[3] and also involvement of Asian patients were reported.[2,4] Unless the lesions are large enough with sufficient overlying RPE atrophy, they are difficult to see clinically and are best illustrated with ICGA.

ICGA has been shown to be useful in differentiating IPCV which may appear clinically as CSCR.[5] As in our case, with the help of ICGA, IPCV can be differentiated from CSCR. Late-phase ICGA in our patient showed the appearance of a punctate hot spot with surrounding hyperfluorescent plaque which is compatible with CSCR.[6] For IPCV, ICGA typically shows the appearance of medium-sized choroidal vessels of the inner choroidal networks that terminate in polypoidal or aneurysmal dilatations, and 'wash-out' appearance of inactive lesions in the late phase.[2] Leakage of the polyps in IPCV is uncommon in ICGA but choroidal vascular hyperpermeability with and without associated active RPE leaks and 'occult' serous RPE detachments may be seen in ICGA of CSCR.[7]

The primary pathology of CSCR favours the choroidal circulation rather than the RPE layer, as demonstrated by ICGA. However, as in the previous case described by Lip *et al.*[1] the exact aetiology of the massive sub-RPE haemorrhage remains uncertain, but is most likely due to the spontaneous rupture of an abnormal choroidal vessel.

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Sir,

Burns to the face from ignition of an eye pad

We report an unusual case with burns to the face from ignition of an eye pad.

Case report

An 85-year-old woman was admitted to our unit after sustaining flame burns to her left eyebrow, forehead and frontal scalp. She was mentally alert and had no tremor. Significant past medical history included diabetes and hypothyroidism. She had just been discharged to a nursing home from the ophthalmology unit having undergone panretinal cryotherapy to her left eye for glaucoma and was therefore wearing an eye pad secured by tape. This was a standard lozenge-shaped pad made of cotton wool sandwiched between two layers of cotton lint.

Whilst igniting a cigarette with a lighter, her eye pad accidentally caught fire. The lighted pad was quickly removed by assistants in the nursing home. She sustained deep dermal and full-thickness burns to her eyebrows, forehead and frontal scalp. These were consistent with a flame burn resulting from ignition of the eye pad itself and resulting in the worst burns immediately superior to it (Fig. 1). Fortunately her cornea and globe escaped any injury.

We elected to manage her conservatively due to her age and infirmity with daily cleaning, debridement and liquid paraffin application to the burnt area. She was subsequently discharged from the hospital after 3 days and arrangements were made for her regular follow-up